FOR ARGUMENT

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In The
Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

v.

KENNETH L. NORD,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

BRIEF FOR RESPONDENT

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STATEMENT OF THE CASE

Introduction

Certain basic facts in this case are not in dispute. Respondent Kenneth Nord worked for Kwikset Lock for 24 years, and was last employed as a materials planner. Kwikset is a California subsidiary of the Black & Decker Corporation, headquartered in Maryland. Prior to 1997, Nord's health problems had not affected his ability to work; he had an exemplary attendance record, and had accumulated more than 700 hours of unused sick leave.

In the spring of 1997, Nord began to experience serious back problems. Although the details of his medical condition are to some degree at issue, there is no dispute that he has both degenerative disc disease and chronic myofascial (soft tissue) pain. Nord saw a number of specialists, and was directed to use powerful pain killers.

In July of 1997, Nord's treating physician ordered him to stop work until his condition improved. Nord's back condition has never gotten better, and he has not worked since the summer of 1997. When Nord stopped working in July, 1997, he had approximately one year of accumulated sick leave, vacation days and other short-term benefits.[1]

In January 1998, Nord applied for disability payments. As an employee of a Black & Decker subsidiary, Nord was an eligible employee and a participant in the Black & Decker Disability Plan. That Plan is self-funded; the company pays any approved disability claims out of its own funds. The Disability Plan ordinarily provides for

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[1] Petition Lodging L-160, L-162.

benefits in an amount equal to 40% of an employee's salary. If, however, the employee opts to pay a sufficient supplemental premium, he or she is eligible for benefits equal to 70% of his or her salary. Nord had chosen to do so.

Under the benefit plan at issue, 30 months of disability benefits are paid until 30 months after he or she leaves work to a worker who can no longer perform his or her job at Black & Decker.[2] At the end of the 30 month period, if an employee is unable to work at all, he or she is eligible for disability benefits until the age of 65.[3]

Black & Decker had contracted with MetLife to process disability claims under the Plan. Nord submitted to MetLife's office in Utica, New York, a variety of supporting materials, relying primarily on the diagnosis and medical records of his treating physicians. On February 16, 1998, MetLife rejected Nord's claim for long term disability benefits,[4] concluding that he was still able to do his job as a materials planner.

Nord requested a review of that determination. Under the terms of the contract between MetLife and Black & Decker, Nord's appeal was first considered by MetLife employees in Utica, who in turn made a recommendation to Black & Decker, the plan administrator. Nord was directed to provide to MetLife any arguments or supplementary

[2] The amount paid is subject to certain deductions and offsets. In the instant case, the total amount of disability benefits that would have been paid to Nord would have been approximately $43,000 for the thirty month period.

[3] Those benefits, of approximately $3,344 a month, would have continued until Nord reached 65. These benefits were subject to certain offsets.

[4] Petition Lodging, L-145.

materials supporting his appeal, and he sent to MetLife the results of a number of additional medical tests and other materials. MetLife asked that Nord submit to an examination by a physician hired by MetLife, Dr. Antoine Mitri, and that examination occurred on July 17, 1998.

On October 15, 1998, MetLife wrote to Black & Decker recommending that Nord's disability claim be denied, enclosing a proposed draft denial letter. On October 27, 1998, Black & Decker rejected Nord's claim, and sent him a denial letter that was essentially the same as the draft that had been prepared by the Metlife employees.[5]

In the February 16 and October 27 letters rejecting Nord's claim, MetLife and Black & Decker, respectively, explained that they had concluded that Nord could still perform his job as a materials planner. In this Court, Black & Decker stresses that it could have made accommodations in the configuration of Nord's job which would have made it possible for him to work despite his back problems. (Pet. Br. 43) In fact, however, Black & Decker did not offer to allow Nord to return to his job, and never offered to him the accommodations suggested by petitioner's merits brief. Instead, in July, 1998, when Nord's other benefits had expired, and while his appeal for disability benefits was still pending, Black & Decker decided to fire him.[6]

While his disability benefit claim was still pending, Nord also applied for disability benefits under Title II of the Social Security Act. The eligibility standards under

[5] Petition Lodging, L-156.

[6] Petition Lodging, L-163.

Title II are more stringent than the standards for the first 30 months of disability benefits under the Black & Decker Plan. In order to qualify for Title II benefits, a claimant must show not only that he or she cannot perform his regular job (the Black & Decker Plan standard for the first 30 months of disability benefits), but also that he or she cannot work at all. 42 U.S.C. § 423. On August 14, 1998, the regional office of the Social Security Administration, concluded that Nord's condition "kee[ps] you from doing your past job."[7] Nord's Title II claim was initially denied, however, on the ground that the agency believed Nord could do some "other jobs". Nord appealed that determination. In February 2000, the Social Security Administration concluded that Nord was in fact totally disabled, and could not work at all. Nord is now living on Title II benefits of approximately $1,300 a month, which are less than one-third of the benefits to which Nord would have been entitled under the Black & Decker Disability Plan.

The Medical Evaluations of Nord's Degenerative Disc Disease

During the nineteen months preceding the benefits denial, Nord was treated by a series of physicians and underwent a wide range of medical tests. Nord's primary care physician was Dr. Leo Hartman, who began treating Nord for his back condition in March 1997, and referred him to a number of specialists. Nord was diagnosed and treated for his back problems by two orthopedists, Dr. Ismael Silva and Dr. Lytton Williams. Their diagnoses were confirmed by Dr. Mumtaz Ali, a neurologist, and by

[7] Petition Lodging, L-38.

Dr. Stanley Katz, a general physician in Dr. Silva's office. The medical records reveal that Nord was examined by these physicians a total of thirty times from March 1997 through April 1998.[8] These physicians prescribed a variety of medicines, including Darvocet, a narcotic pain killer, and Flexeril, a muscle relaxant.

In March and August of 1997, at the direction of Dr. Hartman, Nord had x-rays of his lumbosacral spine. In July, 1997, Nord underwent an MRI of his lumbar spine. In November of 1997, on Dr. Hartman's recommendation, Nord underwent electrodiagnostic studies under the control of Dr. Ali.[9] These test results, as well as the records of Dr. Hartman, Dr. Ali, and Dr. Silva, were submitted to MetLife in connection with Nord's disability application. The tests all demonstrated the existence of degenerative disc disease in Nord's lower spine, a diagnosis in which all three of the physicians concurred. The tests also revealed bilateral radiculopathy, sciatica, a mild diffuse bulge, and degenerative changes in Nord's bilateral lower lumbar spine.[10]

In rejecting Nord's initial application, MetLife's February 1998 letter explained that he had failed to provide information regarding his use of pain killers and his participation in physical therapy.[11] In support of his administrative appeal, Nord provided MetLife with extensive

[8] Although Nord has remained under the care of several physicians, this is the date of the last treatment described in the record before the plan administrator.

[9] Petition Lodging, L-97-100.

[10] Petition Lodging, L-81, L-84, L-99.

[11] Petition Lodging, L-144-45.

documentation regarding both.[12] In addition, MetLife suggested that Nord's pain might be mild enough that it could be controlled by pain killers, thus permitting him to return to work. In response, Nord had two additional sets of medical tests. First, Nord underwent a lumbar discogram, which is an objective measure of the amount of pain emanating from a particular portion of the back.[13] This confirmed the severity of the pain the disc disease was causing. Second, Nord underwent a CT scan of his lumbar spine; it too confirmed the existence of degenerative disc disease.[14] In June, 1998, Nord provided copies of these additional tests to MetLife. (J.App. 20).

Also in April of 1998, both Dr. Williams and Dr. Hartman completed a physical capacity evaluation. They agreed that Nord could not sit for longer than one hour a day, and that he could not lift more than five pounds.[15] These conclusions were each sufficient to preclude Nord from returning to his job as a materials planner. The Human Resources Representative at Kwikset had earlier evaluated Nord's job and concluded that it required five to six hours a day of sitting and lifting objects weighing up to twenty pounds.[16]

Dr. Mitri, the MetLife consulting physician, did not order any further medical tests. His report was based

[12] Petition Lodging L-33-41; J.App. 24-27.

[13] Petition Lodging L-49-50. The discogram indicated a pain level of 7 (on a scale of 0-10) at L5-S1, of 6 at L4-5, and of 3 at L3-4.

[14] This test revealed both annular thinning of the intervertebral discs and a loss of disc space. (Petition Lodging L-51-52).

[15] Petition Lodging L-53, L-83; J.App. 15.

[16] Petition Lodging, L-43; J.App. 32-33.

largely on a "[r]eview of tests" which described the four tests that were done in 1997. But Mitri's report made no mention of the two additional 1998 medical tests that had been undertaken and submitted by Nord for the very purpose of supporting his administrative appeal.[17] It is unclear why Mitri was seemingly unaware of the two 1998 tests. Mitri concluded, "after reviewing the report of [Nord's] tests" and on the basis of a general physical examination, that Nord "should be able to do sedentary work with some interruption by walking in between."[18] Mitri also concluded that Nord should "never" lift objects weighing more than 15 pounds,[19] which was five pounds less than what Nord's job required.

Petitioner's Proffered Explanations for Rejecting Nord's Disability Claim

In its initial February 16, 1998, decision rejecting Nord's disability claim, MetLife set out three reasons for that decision: (1) there was no documentation of Nord's attendance in a physical therapy program, (2) there was no documentation regarding how often Nord required medication, and (3) an office note in Dr. Silva's records stated that Nord was able to tolerate the pain with medication.[20]

[17] Petition Lodging, L-44.

[18] Petition Lodging, L-45. Similarly, in another portion of his report Mitri, after referring only to the 1997 tests, stated that there was "[n]o evidence on . . . test[s] to explain the patient inability to do sedentary job with occasional walking." Petition Lodging, L-48.

[19] Petition Lodging, L-48.

[20] Petition Lodging, L-144-45.

As we explain below, the Black & Decker October 27, 1998, letter rejecting Nord's appeal contained no statement of its reasons for that decision. In the litigation that ensued, however, counsel for the company has proffered a number of different justifications for the rejection of Nord's claim.

In its memoranda in support of Black & Decker's motion for summary judgment, petitioner's counsel set out the following proposed explanations for the company's decision: (1) Nord's pain could be sufficiently controlled by medication so that he could do his job,[21] (2) Nord could sit for the requisite number of hours a day if he stood intermittently,[22] (3) Nord could sit for the requisite number of hours a day if he walked intermittently,[23] (4) the limitations on Nord's ability to lift objects did not matter because his work was "primarily a desk job,"[24] (5) the treating physicians had not provided a written evaluation "that specifically addresses all of the medical tests,"[25] (6) the statements from the treating physicians did not evaluate the specific physical requirements of Nord's job,[26] and (7)

[21] Memorandum of Points and Authorities In Support of Motion for Summary Judgment (filed February 7, 2000) ("February 7 Memorandum"), pp. 1, 11, 12.

[22] February 7 Memorandum, p. 1, 12.

[23] February 7 Memorandum, p. 11, 12.

[24] Defendant's Memorandum of Points and Authorities (filed February 14, 2000) ("February 14 Memorandum"), p. 17 n. 7. This explanation was important because petitioner's Human Resources Representative had stated that Nord's job required him to lift 20 pounds, but Dr. Mitri had concluded that Nord could not lift more than 15 pounds. *See* p. 7, *supra*.

[25] February 14 Memorandum, p. 23.

[26] *Id.*

the treating physicians had merely filled out a form describing Nord's disabilities, but had not provided "a reasoned conclusion that he cannot perform his job."[27] In its brief in the court of appeals, counsel for Black & Decker relied on only the first and last of these reasons.[28]

Finally, in its merits brief in this Court, counsel for Black & Decker now identify a total of seven possible reasons for rejecting Nord's claim: (1) the treating physician's evaluation of Nord's disabilities did not indicate whether they had taken into consideration the effect of pain medication (Pet. Br. 37, 43, 44), (2) the notes of the treating physicians were illegible (Pet. Br. 2 n. 2), (3) the treating physicians were not experts in back problems (Pet. Br. 33-38, 47), (4) the treating physicians were not experts in evaluating work capacity (Pet. Br. 35), (5) the treating physicians did not know the job requirements for a materials planner (Pet. Br. 35, 36, 44), (6) the treating physicians did not take into consideration possible accommodations Black & Decker might have provided to Nord at his job (Pet. Br. 37, 43, 44), and (7) treating physicians are generally unreliable because they falsify records to assist their patients (Pet. Br. 14, 29-33).

SUMMARY OF ARGUMENT

I. The decision of the court of appeals does not require ERISA plan administrators to give any particular amount of weight to the medical opinion of a claimant's

[27] *Id.*

[28] Appellee's Answering Brief, Nord v. Black & Decker Disability Plan, No. 00-55689 (9th Cir.), pp. 4, 15-18.

treating physician. The Ninth Circuit held only that where a plan administrator rejects a claim that was based on such a medical opinion, the administrator must give "specific, legitimate reasons for doing so that are based on substantial evidence in the record." (Pet. App. 13).

II. The obligation of an ERISA plan administrator to give specific reasons for rejecting a benefits claim does not rest on, and is not limited to cases involving, the medical opinion of a treating physician.

Section 1131(1) provides that in *all* cases the plan administrator must provide "the specific reasons for such denial, written in a manner calculated to be understood by the participant." Section 1131(1) serves a number of important purposes. The required statement of reasons gives the claimant notice of what additional information or documents may be needed for a successful or subsequent claim, and provides a basis for judicial review. The requirements of section 1131(1) cannot be satisfied by *post hoc* explanations articulated by a plan's litigation counsel.

Where a benefits claim rests primarily on the medical opinion of a treating physician, the "specific reasons" required by section 1131(1) should ordinarily explain why that medical opinion was deemed insufficient to establish the claimant's entitlement to benefits.

III. The court of appeals held that Black & Decker's failure to provide specific reasons for rejecting Nord's claim, coupled with the company's conflict of interest, required that the denial of Nord's claim be considered de novo. The Ninth Circuit's reliance on the absence of such reasons was unnecessary; the conflict of interest alone was sufficient to require de novo review.

The appropriate standard of review for a claim such as this under section 1132(a)(1)(B) turns on "principles of

trust law." *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989). "The trustee is under a duty to the beneficiary to administer the trust solely in the interest of the beneficiary." Restatement (Second) of Trusts, § 170(1). If a trustee with a direct and substantial conflict of interest makes a decision that is adverse to the interest of a beneficiary, that decision ordinarily is not valid unless it had judicial approval.

A trustee cannot usually make distributions to himself or herself, since every dollar so distributed is a dollar less available for any other beneficiary. 3 A. Scott and W. Fratcher, The Law of Trusts, § 187.6 (4th ed. 1988). Similarly, trustees cannot ordinarily buy property from or sell property to the trust; in such transactions the trustee would face a similarly serious conflict in determining the purchase price. A trustee could, however, apply to the appropriate court for approval of such a distribution or purchase. That judicial approval is analogous to de novo review.

The conflict of interest in this case was direct and substantial. Black & Decker, the plan administrator, paid all disability benefits directly out of its own funds. The claim immediately at issue would have cost the company more than $43,000. If Nord had ultimately established that he was too disabled to work at all, his benefits until age 65 would have totalled approximately $400,000.

In *Tumey v. Ohio*, 273 U.S. 510 (1927), this Court concluded that the judge who convicted Mr. Tumey had an intolerable conflict of interest because he received $12 from the fine paid by the defendant. The conflict of interest in the instant case was far more serious, and assuredly warranted de novo review of Black & Decker's decision.

ARGUMENT

I. THIS CASE DOES NOT RAISE ISSUES REGARDING WHAT WEIGHT SHOULD BE GIVEN BY AN ERISA PLAN ADMINISTRATOR TO THE MEDICAL OPINION OF A TREATING PHYSICIAN

Although petitioner and several amici refer to "*the* treating physician rule", there are – at least in the Social Security context – *two* quite distinct "treating physician" rules.

The first is essentially a procedural rule, developed by the lower courts to provide a principled, consistent standard for reviewing decisions by the Social Security Administration. Where that agency has denied a disability claim that was based on the medical opinion of a treating physician, this procedural rule requires the agency to explain why it rejected that medical opinion.[29] If the agency has failed to provide such an explanation (or if the explanation is legally insufficient, or lacks support in the record), the courts will overturn that decision. Depending on the record and procedural posture of the case, it may either be remanded to the agency for further proceedings or be resolved by the court. 42 U.S.C. § 405(g). In either event, once the court concludes that the requisite explanation is absent (or insufficient), the procedural treating physician rule drops from the case.

The Social Security Administration, on the other hand, has adopted a distinct "treating physician rule"

[29] *E.g.*, *Andrews v. Shalala*, 53 F. 3d 1035, 1041 (9th Cir. 1995); *Magallanes v. Bowen*, 881 F. 2d 747, 751 (9th Cir. 1989).

which controls the evidentiary weight to be given to the medical opinion of such a physician. Ordinarily the agency will give "more weight" to the medical opinion of a treating physician than to other medical evidence. 20 C.F.R. § 404.1527(d). In some circumstances, the agency will give such medical opinions "controlling weight." 20 C.F.R. § 404.1527(d)(2). This evidentiary treating physician rule is applied by the agency before any judicial proceedings occur, and governs the agency's own actions, not any standard of review.[30]

In the instant case the treating physician rule applied by the Ninth Circuit to ERISA cases is the procedural rule, not the evidentiary rule. The court of appeals emphatically did not hold that ERISA plan administrators must give controlling, great, or any particular level of weight to the medical opinions of treating physicians. The decision below merely requires, where a benefit claim is grounded on such a medical opinion, that a plan administrator provide a reason for rejecting that medical opinion. As we explain below, such a procedural rule is clearly mandated by the terms of ERISA itself.

[30] It would, of course, be possible to articulate a justification for one of the rules that would also provide support for the other. Thus the Social Security Administration's explanation for its self-imposed evidentiary rule, that treating physicians "are likely to be the medical professionals most able to provide a detailed, longitudinal picture of [the] medical impairment(s)," 20 C.F.R. § 404.1527(d)(2), might help to persuade the courts that it would be sensible to adopt the procedural treating physician rule in reviewing decisions by the Social Security Administration or others. Regardless of whether they might be justified on similar grounds, the evidentiary and procedural treating physician rules are assuredly distinct doctrines raising decidedly different legal issues.

Several amici argue at length that this Court should not impose the evidentiary treating physician rule on ERISA plan administrators. But the appropriateness of the evidentiary rule under ERISA was not decided by the court below, and is not presented by the instant case. The extent to which these briefs depart from the question actually presented in this case is well illustrated by the brief for the United States. The government correctly observes that under the Ninth Circuit decision

> the treating physician rule requires a plan administrator "who rejects [the treating physician's] opinions to come forward with specific reasons for his decision, based on substantial evidence in the record."

(U.S.Br. 16-17, *quoting Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F. 3d 1130, 1139 (9th Cir. 2001), *petition for cert. pending*, No. 01-1840). This accurate characterization of the decision below is quite different from the government's description of the issue actually addressed by the government's brief.

> This case presents the question whether the administrator of a disability plan covered by . . . ERISA . . . is required, when deciding whether a claimant is disabled, to give special weight to the opinion of the claimant's treating physician.

(U.S.Br. 1).

Petitioner has framed the Question Presented in a manner which artfully blends elements of the two different treating physician rules. It asks the Court to decide whether the Ninth Circuit

> erred in holding that . . . the plan administrator is required to accept a treating physician's opinion of disability as controlling unless the plan administrator rebuts that opinion in writing based upon substantial evidence on the record.

(Petition, i). But the court below does not require plan administrators "to accept a treating physician's opinion," but only insists that they explain their reasons for not doing so.

Neither the petitioner, the government, nor any other amici proffer any explanation of why, in a case involving the procedural treating physician rule, this Court should pass on whether the evidentiary treating physician rule should be applied under ERISA. Given the procedural posture of the instant case, it is at best unclear whether adoption (or rejection) of the evidentiary rule would affect the outcome of this case. That question assuredly should not be addressed in a case, such as this, in which it was never determined by the court of appeals below. Although many of those briefs are directed at language in the Ninth Circuit's opinion in *Regula*, even that decision cannot fairly be read to impose the evidentiary treating physician rule on ERISA plan administrators.

II. AN ERISA PLAN ADMINISTRATOR, IN REJECTING ANY BENEFITS CLAIM, INCLUDING A CLAIM BASED ON THE MEDICAL OPINIONS OF A TREATING PHYSICIAN, MUST STATE SPECIFIC REASONS FOR DOING SO

The court of appeals correctly concluded that the plan administrator in the instant case was obligated to state specific reasons for rejecting the medical opinions of Nord's treating physicians. However, the Ninth Circuit's reliance on the procedural treating physician rule, indeed its reliance on the existence of a treating physician's medical opinion, was unnecessary. Section 503(1) of ERISA, as well

as the implementing regulations, require that in *all* cases in which benefits have been denied the plan administrator must set forth "the specific reasons for such denial." 29 U.S.C. § 1133(1).

A. ERISA and the Department of Labor Regulations Require In Every Case that a Plan Administrator State "Specific Reasons" for Rejecting a Benefits Claim

(1) The text of ERISA itself expressly requires that a written explanation be provided whenever a claim for benefits is denied.

> In accordance with the regulations of the Secretary, every benefit plan shall – (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth *the specific reasons* for such denial, written in a manner calculated to be understood by the participant.

29 U.S.C. § 1133 (Emphasis added). The Department of Labor regulations require both that specific reasons be given for the initial denial of a benefits claim, 29 C.F.R. § 2560.503-1(f)(1) (1981),[31] and that such reasons be given if an appeal of that denial is rejected. 29 C.F.R. § 2560.503-1(h)(3) (1981).[32] The regulations make no reference to the existence of a treating physician's conclusions regarding the claimant's diagnosis, prognosis, or functional capacity (*see* Pet. Br. 25-26), because the statement of reasons is

[31] This requirement is now in section 2560.503-1(g)(i).

[32] This requirement is now in section 2560.503-1(j)(1).

required in *all* cases, regardless of whether the claimant even has a treating physician.

The statement of reasons must be sufficient to impart a meaningful understanding of the basis of the adverse decision. The statute specifies that the explanation must be clear enough to be "understood by the participant." The regulation requires that the explanation set out "[t]he specific reason or reasons for the adverse determination." Thus if the plan administrator has several grounds for rejecting a claim, all of them must be disclosed.[33] Merely referring to a relevant plan provision is not sufficient; the Secretary's guidelines for claim procedures insist that the notice must set out *why* that provision resulted in a denial of benefits.[34]

The mandated statement of reasons serves several important purposes. First, by alerting a claimant to the inadequacy of his claim as it stands, the statement of reasons accords that claimant an opportunity to correct that defect, either by way of further appeal or through a renewed application for benefits.[35] Second, if an employer

[33] *See White v. Aetna Life Insurance Co.*, 210 F. 3d 412, 418 (D.C.Cir. 2000) (overturning denial of benefits because plan administrator failed to disclose one of its reasons).

[34] Pet. App. 66 ("A notice that merely indicates . . . that a rule, guideline, protocol, or similar criterion may have been relied upon does not provide the claimant any specific information about the basis on which his or her claim was decided.")

[35] *Wolfe v. J.C. Penney Co.*, 710 F. 2d 388, 392 (7th Cir. 1983) (the explanation of the denial may be "essential for the participant to fully apprehend the reason for the denial and to know what deficiency must be overcome. . . . An explanation . . . would have apprised Wolfe of the reason for the denial, alerted him to the deficiency of the record accompanying his claim, and thereby aided him in building his claim with additional evidence."); *Richardson v. Central States, Southeast and*

(Continued on following page)

has denied disability benefits because it believes the worker could return to his or her job with a reasonable accommodation, a statement of that reason alerts the worker to the availability of that accommodation and the resulting opportunity to return to work. Third, the necessity for written reasons is likely over time to establish a record of decisionmaking that could be reviewed to assure that the plan administrator acts in a principled and consistent manner.[36] Later claimants could effectively object to proffered reasons that were inconsistent with explanations given in rejecting earlier claims.[37] Fourth, the statement of specific reasons

> enables the claimant to prepare adequately for appeal to the federal courts or further administrative review, and makes it possible for the courts to perform the task, entrusted to them by ERISA, of reviewing that denial.

Halpin v. W.W. Grainger, Inc., 962 F. 2d 685, 693 (7th Cir. 1992).

Southwest Areas Pension Fund, 645 F. 2d 660, 665 (8th Cir. 1981) ("The statute and the regulations were intended to help claimants process their claims efficiently and fairly.")

[36] *Richardson*, 645 F. 2d at 664 (by regularly supplying the statement of reasons required by ERISA "the Trustees may begin to build a body of precedent that will ultimately bring about a form of consistency otherwise lacking in the administration of the Fund"); *see Lang v. Long-Term Disability Plan*, 125 F. 3d 794, 799 (9th Cir. 1997) (noting sharply inconsistent reasons for terminating plan benefits).

[37] For example, if a plan administrator rejected a claim on the ground that orthopedic surgeons are more reliable than neurologists in evaluating back pain, the administrator could not reject a subsequent claim on the opposite ground. Although benefit applications and decisions are ordinarily confidential, suitably redacted copies of those documents would presumably be available through discovery.

Petitioner objects that requiring a plan administrator to give reasons for the rejection of a benefits claim would be "draconian" (Pet. Br. 47), "legalistic" (Pet. Br. 16) and "unduly heavy." (Pet. Br. 13).[38] But that is precisely what the statute and regulations require; petitioner offers no reason why this general requirement should be *in*applicable because a claimant relied on the medical opinions of a treating physician.

Petitioner urges that requiring such a statement of reasons would improperly shift to plan administrators the burden of proof regarding the propriety of a denial of benefits. (Pet. Br. 15, 38, 39, 45). This Court has not had occasion to delineate the circumstances under which a claimant or plan administrator might bear that burden of proof, and need not do so in the instant case. Even where the claimant does bear that burden of proof, requiring the plan administrator to articulate reasons for its decisions would not alter the burden of proof. *Texas Dep't of Community Affairs v. Burdine*, 450 U.S. 248 (1981) (employer's obligation to articulate reasons for disputed action does not shift burden of proof from employee).

The United States suggests that in some instances "it may be reasonably apparent" from the medical or other evidence why the plan administrator rejected a claim. (U.S.Br. 15). But neither the statute nor the Labor Department regulations authorize a court to excuse noncompliance with section 1133 based on judicial speculation, however well reasoned, about the plan administrator's

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[38] In the district court petitioner acknowledged that "[a] plan administrator abuses its discretion when it makes 'a decision without any explanation' " (February 7 Memorandum, p. 7).

unstated reasons. A court need not "scour a record in an effort to justify the plan's decision," *Halpin*, 962 F. 3d at 694, and cannot rely on *post hoc* rationalizations proffered by the plan's attorneys. However plausible such after-the-fact explanations might seem, they would satisfy neither the letter nor the purpose of the controlling statute and regulations.

The mere fact that the record before a plan administrator contained conflicting evidence does not eliminate the need for compliance with the "specific reasons" requirement. Even in the face of such a record, a plan administrator's reason for rejecting a claim might be legally insufficient; a plan administrator could not reject the medical opinion of a treating physician merely because accepting the contrary view of the company's expert would save the employer money. Even if a plan administrator's reason was entirely legitimate, disclosure of that reason could be of great importance to the claimant. If, for example, the plan administrator chose to reject the treating physician's medical opinion because it was several years old, or because a particular type of medical test had not been performed, those would be defects which the claimant could address in further or renewed administrative proceedings.

The court of appeals, consistent with most appellate courts which have addressed this issue,[39] held that the

[39] *E.g.*, *Ellis v. Metropolitan Life Ins. Co.*, 126 F. 3d 228, 232 (4th Cir. 1997); *Bellaire Gen. Hosp. v. Blue Cross Blue Shield*, 97 F. 3d 822, 828-29 (5th Cir. 1996); *Donaho v. FMC Corp.*, 74 F. 3d 894, 899 (8th Cir. 1996); *Miller v. United Welfare Fund*, 72 F. 2d 1066, 1070 (2d Cir. 1995). In *Association of Data Processing Serv. Org. v. Board of Governors of*

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specific reason articulated by a plan administrator must be supported by substantial evidence. (Pet. App. 13, 15). Petitioner repeatedly indicates agreement that this is the correct quantum of supporting evidence (Pet. Br. 28 n. 12, 41, 47), as does the United States (U.S.Br. 14) and most of the amici allied with petitioner.[40]

Elsewhere in its brief, however, petitioner appears to suggest that the reason specified by a plan administrator need not have any evidentiary basis at all. Petitioner urges, for example, that it ought to be able to reject a claim as long as it had a "good faith belief" (however groundless) that a claimant did not meet the relevant criterion. (Pet. Br. 25). But ERISA is not (like the Equal Protection Clause) merely a prohibition against decisions made with an invidious purpose; even under a deferential review it would be an abuse of discretion for a plan administrator to make a decision, however much in good faith, that lacked an evidentiary basis. The substantial evidence rule does not by itself require that a plan administrator hire its own medical expert. (*See* Pet. Br. 15, 25). There

Fed. Reserve System, 745 F. 2d 677, 683 (D.C.Cir. 1984), then Judge Scalia observed:

> "[I]n their application to the requirement of factual support the substantial evidence test and the arbitrary or capricious test are one and the same. The former is only a specific application of the latter, separately recited in the APA not to establish a more rigorous standard of factual support but to emphasize that in the case of formal proceedings the factual support must be found in the closed record as opposed to elsewhere."

[40] Brief of Delta Family-Case Disability, etc., Plan, p.10; Brief of the American Benefits Council, p. 9 n. 4, 15; Brief for Bert Bell/Pete Rozell NFL Player Retirement Plan, pp. 7, 8 n. 2. The district court also applied that standard. (Pet. App. 32).

may be fatal defects in a claimant's own evidence; when that is the case, the administrator need only point to those problems. If, on the other hand, a claimant's evidence is sufficiently competent and credible that it demonstrates (in the absence of contrary expert medical evidence) his or her entitlement to benefits, a plan administrator cannot reject the claim on the ground that it would be costly for the plan to retain the expert needed to verify the claim.

(2) The requirement that a plan administrator provide reasons for the rejection of a claim is neither triggered by nor limited to cases involving the medical opinion of a treating physician. But where, as here, the central documentation on which a claimant relies is the medical opinion of a treating physician, the notice of rejection must be sufficient to permit the claimant, and a court, to understand *why* that medical opinion was deemed insufficient. A proffered explanation cannot fairly be said to give "the specific reasons for such denial" if it provides no account of why the primary evidence offered by the claimant was inadequate. Of course, the reason might be that the evidence was irrelevant (*e.g.*, because the claimant was not covered by the plan), inherently defective (*e.g.*, a brain cancer diagnosis by a podiatrist), overcome by non-medical evidence (*e.g.*, the supposedly wheelchair-bound claimant had been photographed playing hockey), or overcome by more reliable medical evidence (*e.g.*, an additional medical test). But there has to be *some* such explanation.

The United States observes that "in an appropriate case, a plan administrator's failure to adequately address the well-reasoned and documented opinion of a physician may violate ERISA and the Secretary's regulations." (U.S. Br. 16-17). In practice such a failure will at least ordinarily

violate the statute and regulation. It assuredly did so in the instant case.

The denial letter in this case is the very epitome of a non-explanation.[41] The first paragraph promises that the administrators reasons are "noted below." (Petition Lodging, L-115). The second paragraph merely quotes the plan's definition of disability. The third, fourth, and fifth paragraphs summarize the medical opinions of Nord's treating physicians, and the results of supporting medical tests. The sixth paragraph describes Dr. Mitri's report,[42]

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[41] A similar situation was presented in *Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771 (7th Cir. 2003). A number of physicians had concluded that Hackett was too disabled to work, and Xerox had for a time paid him disability benefits. Xerox subsequently retained a Dr. Holeman, who examined Hackett and concluded that he could indeed work. Xerox then terminated the disability benefits. Neither Holeman nor Xerox explained *why* they had rejected the conclusion of the physicians who had earlier examined Hackett.

In reinstating Hackett's benefits, the court of appeals explained:

> "Dr. Holeman provided no explanation for his departure from the opinions of the previous doctors, and Xerox provided no explanation for believing Dr. Holeman's opinion over the opinions of the previous doctors. There was no weighing of the evidence for and against, and there were no articulated reasons given for Xerox's rejection of the evidence that Hackett was unable to work. Conclusions without explanation do not provide the requisite reasoning and do not allow for effective review. . . . We are left without explanation as to why Dr. Holeman's opinion is different from [that of the previous physicians.]"

315 F.3d at 775.

[42] The Mitri report itself does little to clarify the situation. The pivotal portion of Mitri's report is his conclusion that Nord "*should* be able to do sedentary work." Petition Lodging, L-45 (Emphasis added). But that seems to be no more than an assertion that *most* persons with Nord's medical conditions could do such work. As this Court noted in

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with no account (at least none intelligible to a non-physician) of how (or, equally importantly, why) that report differed from the medical opinions of Nord's physicians. The seventh paragraph recites that information provided by Nord only the day before was not "new or different"; that was incorrect, because that information included a then recent determination by the Social Security Administration that Nord was too disabled to return to his job.[43] The paragraph also asserts, without explanation, that

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Toyota Motor Corp. v. Williams, 534 U.S. 184, 200 (2002), the degree of disability caused by a given medical condition can "vary greatly from person to person." It was thus entirely possible that Mitri's conclusion that most individuals with the listed conditions could work was entirely consistent with the conclusion of the treating physicians that Nord himself was among the minority who could not.

If Mitri meant to assert that Nord could in fact do sedentary work and that his treating physicians were thus wrong in concluding Nord could not sit for more than an hour, his report offers no account whatsoever of why he had arrived at a different conclusion, or why his conclusion was the more reliable one. *See Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F. 3d 771, 774-75 & n. 3 (7th Cir. 2003).

In addition, the entire significance of the Mitri report is called into question by the fact that it makes no reference whatsoever to the two 1998 medical tests, which Nord had provided to Metlife a month before his examination by Mitri. We simply do not know (and the plan administrator could not have known) if Mitri was unaware of those medical tests (because Metlife failed to provide them to Mitri, or because Mitri had forgotten them) or simply decided to ignore them.

In any event, ERISA and the Secretary's regulations require that specific reasons for the rejection of a benefit claim be given by the plan administrator, not by a consulting physician. An administrator could, presumably, incorporate by explicit reference the reasons given by a third party, but that did not occur here.

[43] The probative significance of such an agency determination has been widely recognized. *Whatley v. CNS Insurance Companies*, 189 F. 3d 1310, 1314 (11th Cir. 1999); *Ladd v. ITT Corp.*, 148 F. 3d 753 (7th

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a report by a Black & Decker Human Resources Representative was "not sufficient to reverse our [earlier] decision."

The letter concludes that "the medical evaluation supports Mr. Nord's ability to return to work at his own occupation." This simply makes no sense. The issue before the plan administrator was not how to understand "the" medical evaluation, but which of several competing evaluations to accept. At least to a non-physician, it simply is not clear to what extent the medical opinions of Drs. Williams, Hartman and Mitri are consistent, conflicting, or complementary. There is nothing in the letter to indicate that the official who signed it understood any differences among the diagnoses and medical tests, or had identified any basis for concluding that one diagnosis or set of tests was more reliable than the others.

The insufficiency of the October 27, 1998, letter to explain the reasoning (if any) of the plan administrator is underscored by the fact that the actual text of the letter, signed by a plan official in Towson, Maryland, had largely been drafted two weeks earlier by a MetLife claims representative in Utica, New York.

As we noted in the Statement of the Case, in the years since the commencement of this litigation, Black & Decker's able counsel has proffered more than a dozen

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Cir. 1998); *Kirwan v. Marriott Corp.*, 10 F. 3d 784 (1st Cir. 1994); *LaBarge v. Life Ins. Co. of North America*, 2001 WL 109527 (N.D.Ill., Feb. 6, 2001); *Pierce v. American Waterworks Co., Inc.*, 693 F.Supp. 996 (W.D.Pa. 1988); *Ferguson v. Greyhound Retirement and Disability Trust*, 613 F.Supp. 323 (W.D.Pa. 1985).

We do not suggest that Black & Decker was *obligated* to defer to the finding of the Social Security Administration. But surely that determination was significant new support for Nord's claim.

different specific reasons for the company's October 1998 decision to deny Nord's claims. Whether all of these reasons are legitimate, or supported by substantial evidence, is at this juncture irrelevant. ERISA and the Labor Department regulations require that specific reasons be set forth in the decision of the plan administrator; that simply did not occur.

B. Where a Plan Administrator's Decision Would be Entitled to Deferential Review, that Decision Must be Reversed or Vacated if it Lacks the Required Specific Reasons

(1) In the absence of the specific reasons required by ERISA, deferential judicial review of a plan administrator's decision would not be possible. The deference which might appropriately be accorded to a particular type of judgment by a plan administrator is not deference to any decision without regard to why it was made.[44] No deference is accorded to decisions made for illegitimate reasons, or for reasons that lack the support of substantial evidence; decisions made on those unsound grounds must be overturned. The lower courts have repeatedly overturned benefit denials because the plan administrator failed to comply with section 1133.[45]

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[44] *Richardson*, 645 F. 2d at 664 ("Our concern is that we are not only asked to defer to the judgment of the Trustees, but we are also asked to do so without the benefit of a reasoned opinion.")

[45] *E.g.*, *Hackett*, *supra*; *Halpin v. W.W. Grainger, Inc.*, 962 F. 2d 685 (7th Cir. 1992); *Matuszak v. Torrington Co.*, 927 F. 2d 320 (7th Cir. 1991); *White v. Jacobs Engineering Group Long-Term Disability Benefit Plan*, 896 F. 2d 344 (9th Cir. 1989); *Richardson*, *supra*; *Rakoczy v.*

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Where a plan administrator has failed to articulate its reasons, a reviewing court cannot know whether the reason (or reasons) that were the basis for the decision in question is a reason to which deference would be appropriate. For example, it is possible in the instant case, as the court of appeals believed, that the plan administrator decided to reject Nord's claim simply to save Black & Decker money, a plainly impermissible reason. Or, the administrator may have denied the claim in reliance on the interim denial decision, which objected that Nord had failed to produce evidence demonstrating that he had been in physical therapy. A decision on that basis, though arguably legitimate, would lack substantial evidence; following that interim denial Nord provided the plan with undisputed documentation of his participation in physical therapy. Or Black & Decker officials may merely have rubber stamped the form letter that had been prepared by MetLife, without ever attempting to understand and resolve the disputes in this case.

Petitioner's counsel has hypothesized several such possible justifications. But in the absence of a statement of reasons, there is simply no way that a court can know whether a plan administrator acted for a reason that would be entitled to deference, or for a reason that would require reversal.

> "[W]e cannot accept appellate counsel's *post hoc* rationalizations for agency action"; for an agency's order must be upheld, if at all, "on the

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Travelers Ins. Co., 914 F.Supp. 166 (E.D.Mich. 1996); *Bellanger v. Health Plan of Nevada*, 814 F.Supp. 918 (D.Nev. 1993); *Brown v. Retirement Committee of Briggs & Stratton Retirement Plan*, 575 F.Supp. 1073 (E.D.Wisc. 1983).

same basis articulated in the order by the agency itself."

Federal Power Comm'n v. Texaco, Inc., 417 U.S. 380, 396 (1974) (*quoting Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 167-68 (1962)).

If in a given case a plan administrator had given a clearly illegitimate reason (*e.g.*, a desire to save money), the reviewing court, after holding that reason unlawful, would either vacate or reverse the denial of benefits. The court assuredly would not simply excise the offending reason from the written notice of denial and then defer to the sanitized (but now wholly unexplained) decision.[46] Nor would the court permit the plan's attorney to suggest some new legitimate reason, and then defer to that. Surely a plan administrator's decision that gives no reasons at all cannot be accorded greater weight than a decision which rests on a reason that is either illegitimate or lacking in evidentiary support.

This Court has repeatedly applied this principle in other areas of the law in which deferential review exists. For example, under Rule 52 of the Federal Rules of Civil Procedure, a trial judge's findings of fact will be upheld unless clearly erroneous. But if a judge's order is so vague or conclusory that an appellate court cannot understand the basis for a disputed factual finding, the trial court's decision cannot be upheld. *Kelley v. Everglades Drainage Dist.*, 319 U.S. 415, 422 (1943); *Schneiderman v. United States*, 320 U.S. 118, 129-31 (1943). Similarly, a number of decisions made by district judges are matters of discretion; but where a judge has failed to provide an adequate explanation for his or her exercise of discretion, the appellate courts may reverse or vacate that decision. Many decisions by federal administrative agencies are also entitled to deferential review; but the absence of a reasoned account for the agency's action at least ordinarily precludes judicial approval of that action.

[46] *See American Meat Inst. v. Environmental Protection Agency*, 526 F. 2d 442, 453 (7th Cir. 1975) ("If the basis stated by the agency for its decision is insufficient, we may not supply another that the agency itself has not chosen to rely on.").

(2) A statement of specific reasons when an administrative appeal is denied is also essential to assuring that the claimant has been provided the "full and fair review" guaranteed by ERISA. 29 U.S.C. § 1133(2).

Ordinarily an administrative appeal under section 1133(2) will focus on the reasons articulated by the plan administrator for rejecting the initial application. Section 1133(1) requires the administrator to set forth specific reasons for that denial, thus apprising the claimant of the issues which he or she must address in the administrative appeal. The regulations further require that the administrator must also provide the claimant with "[a] description of any additional material or information for the claimant to perfect the claim and an explanation of why such material or information is necessary." 29 C.F.R. § 2560.503-1(g)(1)(iii). Such disclosure of the issues which must be addressed on appeal is essential to the fairness of the review process.

The informal nature of ERISA administrative appeals, however, carries with it the possibility that an appeal might be rejected for reasons never raised in the initial adverse determination, a possibility that involves a considerable risk of violating the statutory requirement of fairness. The plan administrator which resolves such

appeals is not limited to simply accepting or rejecting the reasons specified for the initial denial; the administrator may consider other reasons for rejecting the claim, reasons which may relate to the original record or to additional materials submitted during the review process.

Where a plan administrator during an administrative appeal contemplates relying on such a new reason, the section 1133(1) fairness provision requires that the claimant be provided sufficient notice of that possible disposition to permit the claimant to present materials or argument in response.[47] A review process would obviously be unfair if a claimant did not learn until the issuance of the final administrative decision of the critical objection being raised to his or her claim. Such a process would deprive the claimant of any meaningful opportunity to present evidence or argument regarding the issue deemed of controlling importance by the administrator.[48]

The instant case well illustrates the potential problem. The February 16, 1998 rejection letter set forth three specific reasons for denying Nord's claims; petitioner has

[47] "[T]o be 'full and fair,' the review must provide a claimant with knowledge of the opposing party's contentions and a reasonable opportunity to meet them." *Grossmuller v. International Union, United Automobile Aerospace and Agricultural Implement Workers*, 715 F. 2d 853, 858 n. 5 (3d Cir. 1983). Disclosure is particularly critical where the plan administrator is, in effect, both the opposing party and the judge.

[48] *White v. Aetna Life Ins. Co.*, 210 F.3d 412, 417-18 (D.C.Cir. 2000) (failure to disclose basis for rejecting claim denied claimant fair opportunity to provide the information that the plan administrator deemed essential); *Gellanger v. Health Plan of Nevada, Inc.*, 814 F.Supp. 918, 922-23 (D.Nev. 1993) (overturning denial of benefits because plan administrator failed to disclose at the time of the decision one of the bases on which it was rejecting the claim).

largely abandoned any reliance on those objections. But since the commencement of this litigation, counsel for petitioner has adduced more than a dozen new possible reasons for the rejection of Nord's claims. Many of these new reasons relate to issues that were never raised, or at least openly so, during the administrative appeal. For example, Black & Decker now objects that the notes of the treating physicians were "illegible." (Pet. Br. 2 n. 2). If that argument had been raised during the administrative appeal, Nord could have arranged to have the notes transcribed. Black & Decker argues in this Court that the treating physicians in this case lacked sufficient expertise in back problems. (Pet. Br. 33-38). If that issue had been brought up during the administrative appeal, Nord could have retained a consulting physician with whatever expertise the plan administrator thought was essential.

If Nord's administrative appeal had been expressly rejected on such new grounds, that adverse determination would at least presumptively have been reversible for violating the statutory fair hearing requirement. In the absence of any specifically stated reasons for the adverse decision on appeal, however, it simply is not possible to determine whether the section 1133(2) fairness requirement was satisfied.

(3) Where a plan administrator has violated the ERISA procedural requirements, the appropriate remedy may be to remand the case to the administrator for further consideration, or to order an award (or reinstatement) of benefits. In some instances de novo review may be the

proper judicial response to that violation.[49] Where the record is complete, and it is clear that a denial on remand would ultimately have to be overturned by the courts, such a remand would serve no purpose.[50] The court may also impose penalties on the plan administrator.[51]

In most cases, as here, the ongoing award of disability benefits to a claimant remains subject to reconsideration by the plan administrator. Thus a judicial decision awarding disability benefits would not necessarily be permanent. Such an award functions, as a practical matter, much like a preliminary injunction awarding disability benefits until, and unless, the administrator reopens the matter and concludes that the claimant does not meet (because of a change of circumstances or otherwise) the requirements for such benefits.[52]

The determination of whether to make such an award, or simply to remand the case to the administrator, is ordinarily a matter within the discretion of the district court. At least ordinarily a decision to award such benefits would not be an abuse of discretion. The harms caused by a wrongful denial of benefits often cannot be undone by a retroactive monetary relief awarded long after that initial

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[49] *E.g.*, *Matuszak v. Torrington Co.*, 927 F. 2d 320, 322-23 (7th Cir. 1991).

[50] *E.g.*, *Bellanger v. Health Plan of Nevada*, 814 F.Supp. 918, 924-25 (D.Nev. 1993); *see Harman v. Apfel*, 211 F. 3d 1172, 1174 (9th Cir.), *cert. denied*, 531 U.S. 1038 (2000).

[51] *E.g.*, *Garred v. General American Life Insurance Co.*, 774 F.Supp. 1190, 1201-02 (W.D.Ark. 1991).

[52] *See Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F. 3d 771, 776-77 (7th Cir. 2003); *Halpin v. W.W. Grainger, Inc.*, 962 F. 2d 685, 697-98 (7th Cir. 1992); *Grossmuller*, 715 F. 2d at 859-60.

error. Where an out of work claimant must rely on disability benefits to meet the necessities of life, he or she may have to endure years of indigence while those benefits are wrongly being withheld. *See Schweiker v. Chilicky*, 487 U.S. 412, 415-17 (1988). A lump sum payment at the end of that period cannot erase the suffering that occurred in the interim. *See Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985) (ERISA precludes extracontractual damages needed to make a claimant whole).

If the courts were routinely to remand such cases, that practice could create a substantial disincentive for plan administrators to comply with section 1133(1). In the absence of any predictable adverse consequence for violations of section 1133(1), a plan administrator might deliberately choose to give no reasons for a denial, in order to avoid the risk that an articulated reason might be held to be illegitimate or to lack substantial supporting evidence. In the absence of any stated reason, a claimant might be deterred from suing because of his or her resulting inability to assess the likelihood of prevailing in court. Even if the claimant did sue, and the court found that section 1133(1) had been violated, the plan administrator would be no worse off, and might obtain from the court's decision useful guidance regarding how on remand to frame a denial decision that the judge would regard as sound.

C. Where a Plan Administrator's Decision Subject to De Novo Judicial Redetermination Lacked the Required Specific Reasons, the Plaintiff is Entitled to Insist on Administrative Reconsideration of his or her Eligibility

The failure of an administrator to give specific reasons for an adverse determination, although a violation of ERISA, would not preclude a court from determining de novo whether a claimant was entitled to benefits. A judicial determination of that issue – in this case, for example, a decision about whether Nord is so disabled that he could not do his old job at Kwikset – would not ordinarily be affected by any procedural errors that had occurred during the earlier administrative process.[53]

But a claimant who is entitled to a de novo determination of his or her eligibility is also entitled to an administrative determination untainted by procedural error. Where the administrative determination was flawed in some manner, the claimant may choose to insist that a court proceed to make that de novo determination, but the claimant is not required to do so. If the administrative determination is tainted by procedural error, the claimant may instead ask that the case be remanded to the plan administrator for reconsideration.

There may be sound practical reasons why a claimant might choose such a remand rather than an immediate

[53] Those errors might matter if they had resulted in a limitation on the evidence which the claimant was able (or on notice that he or she needed) to put in the administrative record. In such a case, of course, the court could simply reopen the record.

(and ultimately inevitable) de novo determination. First, the claimant may conclude that there is a reasonable possibility that the plan administrator, proceeding in a manner unencumbered by procedural error, may on remand approve the claim. Second, if additional favorable evidence has become available since the earlier administrative review, a remand will afford the claimant an opportunity to supplement the record that will be before the administrator.[54] Third, even if the claimant does not prevail on remand, the plan administrator's decision may narrow the issues that will need to be litigated before the court, deciding some but not all questions in the claimant's favor.

If a claimant has already exhausted his claim in the administrative process, and review is de novo, remand should not be ordered over the objection of the claimant. ERISA requires only that a plan's administrative process be exhausted once; the failure of a plan administrator to comply with ERISA's procedural requirements cannot impose on the claimant whose procedural rights were violated an obligation to exhaust that process for a second time. In a case involving deferential review, remand may appear appropriate because a procedurally defective decision may well not include any decision to which deference could be given. But if de novo judicial determination is to occur, a remand for that reason would never be necessary.

[54] There is a division among the lower courts regarding whether a claimant may supplement the record before the court. *See Jorstad v. Connecticut General Life Ins. Co.*, 844 F.Supp. 46, 55 (D.Mass. 1994) (citing cases).

III. THE INSTANT CASE IS SUBJECT TO DE NOVO REVIEW BECAUSE THE PLAN ADMINISTRATOR HAD A DIRECT AND SERIOUS CONFLICT OF INTEREST

The appropriate disposition of this case turns on the applicable standard of judicial review. If Nord's benefits claim is subject to de novo consideration, the decision of the court of appeals should be affirmed.[55] If, on the other hand, the plan administrator's decision is entitled to some degree of deference review, the case should be remanded to the lower courts to decide whether to award disability benefits or to return the claim to the administrator for further consideration.

The court of appeals properly concluded that the claim in this case is subject to de novo judicial determination. The Ninth Circuit based this conclusion on a combination of two circumstances: the fact that the plan administrator was subject to a conflict of interest, and the administrator's failure to provide the requisite specific reasons for rejecting Nord's claims. The appellate court's reliance on the lack of that explanation was unnecessary. Petitioner did not dispute the district court's finding that there was a conflict of interest. (Pet. App. 31). The conflict of interest was entirely sufficient by itself to mandate de novo review.

[55] Having concluded that the claim in this case was subject to de novo judicial determination, the court of appeals concluded that summary judgment should be granted to Nord. As we explain *infra*, part IV, the correctness of that portion of the court of appeals' decision is not within the scope of the Question Presented.

(1) Under trust law the paramount obligation of a fiduciary is complete loyalty to the interests of the beneficiaries. "The trustee is under a duty to the beneficiary to administer the trust solely in the interest of the beneficiary." Restatement (Second) of Trusts, § 170(1). A trustee "is not permitted to place himself in a position where it would be for his own benefit to violate his duty to the beneficiaries." 2 A. Scott & W. Fratcher, The Law of Trusts § 170 at 311 (4th ed. 1987). ERISA expressly imposes that same duty. "[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries. . . . " 29 U.S.C. §§ 1104(a)(1), 1104(a)(1)(A)(i).

> Under ERISA . . . [e]mployers . . . can be ERISA fiduciaries and still take actions to the disadvantage of employee beneficiaries, when they act as employers . . . or even as plan sponsors. . . . ERISA does require, however, that the fiduciary with two hats wear only one at a time, and wear the fiduciary hat when making fiduciary decisions.

Pegram v. Herdrich, 530 U.S. 211, 225 (2000).

This Court has repeatedly noted with considerable concern the problems created when an ERISA plan administrator is subject to a conflict of interest.

> *NLRB v. Amax Coal Co.*, 453 U.S. 322 (1981), stressed that the fiduciary provisions of ERISA were designed to prevent a trustee "from being put into a position where he has dual loyalties, and, therefore, he cannot act exclusively for the benefit of a plan's participants and beneficiaries." H.R. Conf. Rep. No. 930-1280, . . . 309.

453 U.S. at 334.[56] In *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court recognized that such a conflict of interest would affect the degree of judicial scrutiny. "[I]f a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.' Restatement (Second) of Trusts § 187, comment *d* (1959)." 489 U.S. at 115.

Most recently in *Rush Prudential HMO, Inc. v. Moran*, 122 S.Ct. 2151 (2002), the Court explained that

> [i]n *Firestone Tire* itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised. That last observation was underscored only two Terms ago in *Pegram v. Herdrich*, 530 U.S. 211 (2000), when we again noted the potential for conflict when an HMO makes decisions about appropriate treatment, see *id.*, at 219-20. It is a fair question just how deferential review can be when the judicial eye is peeled for conflict of interest.

122 S.Ct. at 2169 n. 15. This Court has not, however, resolved what standard of scrutiny should apply where such a conflict of interest is present. *See Firestone Tire*, 489 U.S. at 115 (Court expressly did not address the concern for impartially that was the basis of the lower

[56] *See id.* at 333-34 ("The legislative history of ERISA confirms that Congress intended in particular to prevent trustees 'from engaging in actions where there would be a conflict of interest with the fund. . . .' S.Rep. No. 93-383, pp. 31, 32 (1973).").

court's decision); *Rush*, 122 S.Ct. at 2169 n. 15 (case did not require resolution of this issue.)

In *Firestone Tire*, the United States, in a brief joined by the Solicitor of Labor, urged that de novo review was the appropriate standard where an ERISA plan administrator was subject to a serious conflict of interest.

> The inherent nature of the conflict faced by the employer-administrators of unfunded plans entails an unqualified rule of no deference in cases involving unfunded plans administered by employers. Any alternative would sow confusion in the courts and foster inconsistent enforcement of benefit rights under these plans. . . .

Brief for the United States, No. 87-1054, Firestone Tire and Rubber Co. v. Bruch, No. 87-1054, p. 22.[57] That is the standard that should be applied in the instant case.

(2) "In determining the appropriate standard of review for actions under § 1132(a)(1)(B) we are guided by principles of trust law." *Firestone Tire*, 489 U.S. at 111. Trust law deals in two quite distinct ways with a conflict of interest, depending on the seriousness of the conflict involved.

Where a trustee's action involves merely a potential conflict of interest (*e.g.*, any financial consequences for the trustee might depend on unpredictable future events over which the trustee has no control), or the financial consequences for the trustee are de minimis, the courts will

[57] *See id.* at 7 ("a 'flexible' arbitrary and capricious standard, whose rigor varies in an ad hoc basis with the appearance of bias on the part of the administrator . . . would only create confusion as to the proper standard of review. . . . [T]here is no good reason to defer to an employer's construction of the terms of an employee benefit plan when it is paying benefits out of its own pocket.").

continue to use a degree of deferential standard.[58] The existence of that conflict, however, will be a "facto[r] in determining whether there is an abuse of discretion." Restatement (Second) of Trusts, § 187 comment *d* (1959).

If, however, the trustee's personal interest in a decision is direct and substantial, trust law generally insists that someone other than that trustee must make the decision in question. "Such transactions are irrebuttably presumed to be affected by a conflict between personal and fiduciary interests. It is immaterial whether the trustee acts in good faith. . . . " Uniform Trust Code, § 802 comment.[59] Where a trustee must make a decision in which he or she has such a personal interest, the trustee ordinarily must seek advance judicial approval.[60]

[58] *See* Restatement (Second) of Trusts, § 170 comment *c* (duty of loyalty violated where trustee has "a personal interest . . . of such a substantial nature that it might affect his judgment").

[59] Bogert on Trusts, § 95, p. 342 (6th ed. 1987) ("It is a well-known quality of human nature that it is extremely difficult, or perhaps impossible, for an individual to act fairly in the interest of others whom he represents and at the same time to consider his own financial advantage. In most cases, consciously or unconsciously, he will tend to make a choice which is favorable to himself, regardless of its effect on those for whom he is supposed to be acting. . . . For the sake of protecting [beneficiaries] against this risk equity forbids the disloyal transaction and does not consider its actual merits or effects . . . ").

[60] G. Bogert and G. Bogert, The Law of Trusts and Trustees, § 543 pp. 476 ("If peculiar circumstances make it necessary to allow the trustee to act for himself as well as for the beneficiaries with regard to a particular transaction, relief can be had by an application to the court"), 590 (2d ed. 1960); Bogert on Trusts, p. 347 ("For good cause shown the courts sometimes approve the doing of an act which would otherwise be objectionable as disloyal"); Uniform Trust Code, § 802(b)(2) (normally impermissible sale between trustee and trust allowed if "the transaction was approved by the court"); Uniform Trust Powers Act, § 5

(Continued on following page)

For example, ordinarily trustees cannot make discretionary distributions to themselves. 3 A. Scott and W. Fratcher, The Law of Trusts, § 187.6 (4th ed. 1988). In such a situation, every dollar distributed to the trustee himself or herself would be a dollar less available to the other beneficiaries. Where a trust instrument authorizes distributions to a trustee, in some jurisdictions the trustee must apply to the appropriate state court for judicial approval of any such distribution.[61] A number of states have adopted statutes authorizing a court to appoint a special trustee to make decisions regarding distributions to the named trustee. *Id.*; A. Scott and W. Fratcher, The Law of Trusts: 2002 Cumulative Supplement, § 187.6.

Similarly, trustees are generally forbidden to buy property from, or sell property to, the trust. Restatement (Second) of Trusts, § 170 comment *b*. In such transactions the trustee would face a serious conflict of interest in determining the price of the sale. In the case of a sale to the trust, for example, every additional dollar paid to the trustee for the property would be a dollar less remaining for the beneficiaries. The trustee may seek judicial approval of his or her purchase from the trust, but "[t]he court will permit a trustee to purchase trust property only if in its opinion such purchase is for the best interest of the

(court, upon notice to the beneficiary, may relieve trustee of restrictions on his power); Rev. Stat. Neb. § 30-2822(2) (2001) (any transaction involved a "substantial conflict of interest" not voidable if "the transaction is approved by the court after notice to interested persons"); Utah Code Ann. § 75-7-404 (1993).

[61] *E.g.*, *Watson v. Dietz*, 702 S.W.2d 407, 408 (Ark. 1986); *Armington v. Meyer*, 236 A.2d 450, 456 (R.I. 1967); *In re Peabody's Will*, 98 N.Y.S.2d 614, 616 (A.D. 2d 1950).

beneficiary." *Id.*, comment *f*. Sales by or to a trustee are usually voidable at the request of the beneficiaries. As a practical matter, a sale of property involving the trustee and the trust will stand only if the interested beneficiaries agree with the transaction between the trustee and the trust will.

Under the plan at issue in this case, Black & Decker had the most direct and immediate conflict of interest.[62] The disability plan at issue is unfunded; all benefits are paid directly from Black & Decker's own funds. Every dollar paid to a beneficiary was a dollar out of the company's pocket. The economics of this relationship is indistinguishable from a trustee making distributions to himself. 273 U.S. at 533.

In *Tumey v. Ohio*, 273 U.S. 510 (1927), this Court held that the due process clause invalidated a fine imposed by a village mayor, acting as a judge, who was entitled to a portion of the fine paid. In that case the mayor received only $12 of a $100 fine.

> There are doubtless mayors who would not allow such consideration as $12 costs in each case to affect their judgement in it; but the requirement of due process of law in judicial procedure is not satisfied by the argument that men of the highest honor and the greatest self-sacrifice could carry it on without danger of injustice.

[62] The methods under which ERISA benefit plans are funded, and the potential financial impact on an employer-fiduciary or approval of benefit claims, vary greatly. This case does not require the Court to assess the seriousness of the conflict of interest, if any, that might exist under other plans.

273 U.S. at 532. The Court concluded that due process would also have been violated because of the likelihood that the mayor, naturally concerned with the financial interests of the village he represented, might be swayed by that concern in his adjudication of offenses.

The financial interest of the mayor and village in *Tumey* is far smaller than the interest of Black & Decker in denying Nord's benefits claim. In the instant case the disability payments to which Nord would have been entitled, and thus the cost to Black & Decker, were quite substantial. If Nord were unable to work at his regular job, he would have been entitled to thirty months of benefits with a net total value of more than $43,000. If Nord were thereafter found unable to work at all, he would have been eligible for continued benefits of approximately $40,000 a year, subject to certain offsets, for another fifteen years, until he was 65.[63] By rejecting Nord's claims, company officials saved Black & Decker approximately $400,000. That rejection enabled the company to turn a modest additional profit, since the company was able to pocket without any ensuing liability the money that Nord had for years paid to Black & Decker to obtain a higher level of disability benefits.

The duty of loyalty owed by Black & Decker employees to their employer, and to the company stockholders, would ordinarily obligate them to avoid, if possible, paying

[63] Nord would have been approximately 50 when he became eligible for long-term disability payments of $3,400 a month, subject to certain offsets. If payments had continued at that rate until Nord was 65, they would have totalled almost $400,000, in addition to the $43,000 that would have been owed for the first thirty months of disability.

such a claim.[64] At the least, they would be obligated to search diligently for any evidence or argument that could provide a plausible basis for saving the firm the considerable expense at issue, and to assess all the available information in the light and manner most favorable to Black & Decker. The duty of loyalty which those employees owed to Nord as plan fiduciaries, however, was quite the opposite.

An employer, when it acts as a plan sponsor, can fashion its benefit scheme in any way which does not violate the limited substantive prohibitions of ERISA. "[A]n employer's decisions about the content of a plan are not themselves fiduciary acts." *Pegram v. Herdrich*, 530 U.S. 211, 226 (2000). But when an employer acts as a fiduciary, it is presumptively subject to all the constraints and remedies of trust law. Thus ERISA permits an employer to designate itself as the fiduciary administering a benefit plan, and it allows the employer to establish a plan which is wholly unfunded or under which, as a practical matter, every dollar paid out in benefits must be replaced by a dollar from the employer itself. But if an employer selects to do *both* of these things, trust law principles apply to protect the beneficiary from the very real danger

[64] The Third Circuit's description of the conflict of interest in *Bruch v. Firestone Tire and Rubber Co.*, 828 F. 2d 134 (3d. Cir. 1987), *aff'd in part and rev'd on other grounds*, 489 U.S. 101 (1989), is applicable here:

> "The plan is controlled entirely by the employer. . . . Because the plan is unfunded, every dollar provided in benefits is a dollar spent by defendant Firestone, employer; and every dollar saved by the administrator on behalf of his employer is a dollar in Firestone's pocket."

828 F. 2d at 144.

that the employer's decisions as plan fiduciary may be affected by the conflict of interest that results. In sum, trust principles give an employer a clear choice. If the employer wishes to act as the plan administrator, controlling directly how much of its money is spent on beneficiaries, its decisions as fiduciary will not be accorded deferential review. If, on the other hand, the employer wants the plan administrator to enjoy the benefits of deferential review, it must designate a plan administrator without a serious conflict of interest. An employer can choose either control or deferential review, but it cannot have both.

(3) In the absence of de novo review, litigation of ERISA claims involving a serious conflict of interest would be intolerably complex.

Black & Decker acknowledges that under *Firestone Tire* any conflict of interest requires, at the least, a more stringent application of the abuse of discretion standard. (Pet. Br. 40). But as petitioner and several supporting amici note, a requirement of more searching but still deferential review provides the lower courts with little guidance as to when erroneous benefit denials should be upheld out of deference to the plan administrator.[65] Where, as here, there is a direct and substantial conflict of interest, de novo review provides a clear and familiar standard of review.

[65] Pet. Br. 42 & n. 17; Brief of the American Benefits Council, pp. 10-11 and n. 5; Brief Amicus Curiae of the National Association of Manufacturers, p. 7 n. 12; Brief of the American Council of Life Insurers, p. 24.

Regardless of the applicable standard of review, an ERISA claimant is always entitled to prove that the fiduciary violated section 1104 because its rejection of aclaim for benefits was in fact affected by the fiduciary's own financial interest. A benefits decision tainted by *actual* bias on the part of the fiduciary could not be upheld, no matter how reasonable it might be[66]. The existence of any conflict of interest on the part of the fiduciary is likely to create a triable issue of fact as to the fiduciary's actual motives[67]. Resolution of such questions of motive would involve application of the well-developed standards for proving unlawful intent. *E.g.*, *Reeves v. Sanderson Plumbing, Inc.*, 530 U.S. 133 (2000); *Arlington Heights v. Metropolitan Housing Dev. Corp.*, 429 U.S. 252 (1977).

The sort of conflict of interest involved in this case would often be sufficient to prove actual bias. This Court noted in *Pegram*,

> A plan might lawfully provide for a bonus for administrators who denied benefits to every 10th beneficiary, but it would be difficult for an administrator who received the bonus to defend

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[66] Restatement (Second) of Trusts, § 187 comment *g*:

"The court will control the trustee in the exercise of a power where he acts from an improper even though not a dishonest motive, that is where he acts from a motive other than to further the purposes of the trust. Thus, if the trustee in exercising or failing to exercise a power does so because of . . . some interest of his own . . . the court will interpose."

[67] *Id.* ("The fact that the trustee has an interest conflicting with that of the beneficiary is a circumstance that the court may properly consider in determining whether the trustee is acting from an improper motive in the exercise of a discretionary power.") 3 A. Scott and W. Fratcher, The Law of Trusts, p. 47 (4th ed. 1988) (footnote omitted).

> against the claim that he had not been solely attentive to the beneficiaries' interests in carrying out his administrative duties.

530 U.S. at 227 n. 7. Under the plan at issue in the instant case, the plan administrator (Black & Decker) gets a bonus (equal to the size of the claimed benefit) for *every* claimant to whom it denies benefits.

Even in the absence of any conflict of interest, moreover, greater scrutiny is given to the decision of a trustee where a beneficiary's claim turns on the determination of a question of fact (i.e., how long can Nord sit without experiencing serious pain).[68] Thus, in the instant case, scrutiny of Black & Decker's decision would have to be doubly searching, a standard likely in at least some cases to amount to de novo review, and certain in all cases to pose perplexing problems of interpretation. Rather than insist that the lower courts divine what that might mean, it would be far simpler to provide for de novo review whenever a direct conflict of interest is present.

The Ninth Circuit in the instant case, as in *Regula v. Delta Family-Care Disability Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), applied a hybrid standard. De novo review is utilized if an employer both had a conflict of interest and also failed to explain its rejection of the treating physician's medical opinion. Other procedural violations by the plan administrator could presumably have a similar effect. This constitutes, at best, an unnecessarily complex solution to the problem. At worst it protects beneficiaries only from biased fiduciaries too inept to comply with the ERISA procedural requirements.

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[68] 3 Scott on Trusts, p. 37.

If an employer were to establish and make contributions to a funded benefit plan whose decisions it then controlled, deferential judicial review could raise troublesome tax issues. In the absence of de novo review, there would exist a class of benefit claims over which the employer would have essentially total control of whether the employee received the benefits promised by the plan. In such a situation, the employer could not fairly be said to have relinquished control of funds contributed to the plan, and a business deduction might be permissible only when funds were actually disbursed by the plan, but not for the employer's contributions to that plan.[69]

IV. THE COURT OF APPEALS' DECISION TO AWARD SUMMARY JUDGEMENT SHOULD NOT BE DISTURBED BY THIS COURT

The Ninth Circuit, correctly applying a de novo review standard, concluded that the record warranted an award of summary judgment to Nord. Although Black & Decker objects to the utilization of that standard of review, its merits brief does not contend that the Ninth Circuit misapplied the de novo standard, or that it was error to award summary judgment under that standard. The Question Presented relates only to the propriety of the (procedural) treating physician rule, and cannot fairly be understood to encompass a fact-bound dispute about whether Black & Decker adduced sufficient evidence to survive a motion for summary judgment. Petitioner did

[69] *See* B. McNeil, Non-Qualified Deferred Compensation Plans (2002).

not ask this Court to grant review of that factual controversy, which affects only the parties to the instant case.

The United States invites this Court to address that fact-bound case-specific issue. The government asks this Court to hold that the Ninth Circuit "erred" in holding that there was no genuine issue of fact regarding Nord's disability. The government does not, however, suggest that the Ninth Circuit's evaluation of the evidence was affected in some way by the procedural treating physician rule,[70] and does not explain why it believes – if indeed it does – that this fact-specific issue is fairly included within the Question Presented.

[70] Several amici suggest that the Ninth Circuit opinion concerns the weight that should be accorded to the medical opinion of a treating physician. As we explain in Part I, *supra*, the court of appeals did not address that question.

CONCLUSION

For the above reasons, the decision of the court of appeals should be affirmed.

Respectfully submitted,

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